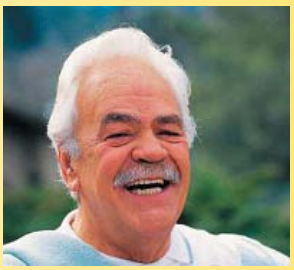
California Partnership for Long Term Care

California Department of Health Services

California Partnership for Long-Term Care

# 2006 Comprehensive Brochure



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**Nearly half of people over age 65**
**will have at least one stay in a nursing home.**
**Source: New England Journal of Medicine (Feb. 28, 1991)**

# Welcome

Thank you for requesting information on the State of California's Partnership for Long-Term Care program. Your decision to invest in long-term care insurance is an important one, but we appreciate that this can also be a very complex topic. For that reason, this booklet offers a comprehensive overview of the California Partnership for Long-Term Care's program, and answers commonly asked questions regarding long-term care insurance.

You should understand that neither the State of California nor its program, the California Partnership for Long-Term Care (Partnership) sell insurance policies. Instead, the Partnership serves as an innovative public/private alliance between consumers, the State of California, and select private insurance companies, as well as the California Public Employee's Retirement System (CalPERS).

The first priority is to decide whether long-term care insurance is the approach you and your family wish to take in safeguarding your family and your investments against the costs of long-term care. In the face of skyrocketing long-term care costs, this is an essential part of any financial planning. Because of the demands that can be placed on the entire family when anyone within the family unit needs long-term care, it is important that you talk with your family about how you intend to have your long-term care needs met in the future.

If you are interested in having long-term care insurance for yourself, your spouse or your loved ones, we urge you and your family to meet with a qualified agent who can more completely describe the Partnership-certified policies and discuss which policies best meet your needs.

Carol A. Freels

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Program Director
California Partnership for Long-Term Care

# Introduction

The California Partnership for Long-Term Care (the Partnership) is a program of the California State Department of Health Services (DHS). DHS is charged with protecting the overall health of Californians. The Partnership is dedicated to protecting the welfare of Californians against the potentially devastating emotional and financial costs associated with paying for long-term care. Partnership-certified policies are designed to offer you the assurance of purchasing a quality product as well as the flexibility to select a policy designed to meet your specific needs.

This brochure provides vital information you need to plan for how you are going to receive and pay for your (or your loved one's) long-term care. Section One provides general information on the risks of needing long-term care.

Section Two provides a detailed understanding of the Partnership and why the special consumer protection provisions required to be included in all Partnership policies are so important.

Section Three includes general information on long-term care insurance, most of which comes directly out of the "Long-Term Care Insurance Company Rate & History Guide, developed by the California Department of Insurance.

Section Four includes a glossary of commonly used terms related to long-term care and long-term care insurance, as well as a list of resources to help in long-term care planning.

# Section One: The Risks of Needing Long-Term Care

## A. What is long-term care?

Long-term care is the assistance needed over an extended period of time to manage, rather than cure, a chronic condition, such as, arthritis, a stroke, dementia, or the frailties of aging or accidents.

Long-term care is not typically covered under health insurance policies, HMO plans, Medicare or Medicare supplemental policies, which are designed to provide coverage when you receive care from a doctor or treatment in a hospital. If these policies cover nursing home care or home care at all, it is only for a short-term or limited basis.

Long-term care is primarily the assistance or supervision you may need when you are not able to do some of the basic "activities of daily living" (ADLs), such as bathing, dressing, toileting, or moving from a bed to a chair. You might need assistance with ADLs if you suffer from an injury like a broken hip, prolonged illness, a stroke, or advanced age and frailty. Other people may need long-term care because of mental deterioration, called "cognitive impairment" that can be caused by a brain disorder such as Alzheimer's, or a mental illness.

Long-term care is sometimes called "custodial care" or "personal care." Family members and friends frequently provide it. "Formal" long-term care (the kind of care you must pay for) is most often provided by unskilled workers such as homemakers, companions, or personal care aides. While less common, "Formal" care can also include skilled care from medical professionals such as nurses and physical therapists.

Long-term care services can be provided in your own home or in a community program like an Adult Day Care Center, in an assisted living facility licensed as a Residential Care Facility (RCF)

or in a nursing facility. Long-term care is not necessarily "long term." For instance, about half of all nursing home stays last six months or less. Some people only need long-term care for a few months, for example, while recovering at home from a broken hip. Others, however, may need care for the rest of their life.

## B. Will I need long-term care and if so, will I need to be in a nursing facility?

Unfortunately, while none of us want to consider the probability, everyone is at risk of needing long-term care. A 1990 study, "The Risk of Nursing Home Use in Later Life," found that nearly half of people over 65 years of age would spend some time in a nursing facility. At age 75, the risk increases to 50 percent, and at age 90, this risk increases to 75 percent. These statistics only cover care in nursing facilities and do not include people who only receive care at home.
Your personal risk of needing long-term care depends on many factors, such as longevity, your gender, marital status, and health history.

- **Longevity:** The longer you live; the more likely it is that you will need long-term care. Those who live to be 95 years old or older are much more likely to have spent five or more years in a nursing home than those who live to their mid-70's. Fewer facts are known about the use of home care services, although for every person in a nursing facility, there are four people receiving the same care in their homes.

- **Gender:** According to a study completed by the New England Journal of Medicine, February 28, 1991, one out of every two women over the age of 65 will spend some time in a nursing facility. Women are at a much higher risk of needing to pay for formal long-term care for several reasons. Women have longer life spans and often out-live their spouses. When they need long-term care in their older years there is often no one to care for them at home and, as a result, are more likely to need institutional care. Additionally, women are more prone to chronic diseases such as arthritis and osteoporosis, conditions that frequently result in a need for long-term care.

- **Married or Single:** If you have a spouse (or other family or friends) who can provide your care whenever it is needed in the future, you are more likely to be able to remain in your home rather than move into a RCF or a nursing facility to receive your long-term care.

- **Health factors:** Certain health conditions, such as severe Arthritis, Alzheimer's or stroke, can cause a need for long-term care. If you know that certain health conditions run in your family, you may have a greater risk of needing long-term care than another person of the same age and gender.

## C. Who will take care of you?

Almost none of us are willing to accept that we are likely to need care in a nursing facility in the future. Most of us are in denial that we will ever need assistance with eating, dressing, bathing, toileting, or moving about our homes. If we ever need such assistance, we believe we will be able to receive it at home. Many of us assume our adult children will take care of us. Yet, many family members will find it difficult to provide an adequate level of care, even though they will likely want to try. In addition, family caregivers frequently see dramatic changes in their own lifestyles that negatively impact their relationship with their spouse, children, and even the loved ones for whom they are caring.

Because caregivers are often full-time employees, their job productivity and ability to advance in their careers is also negatively impacted. Some have to quit work entirely.

## D. How Much Does Long-Term Care Cost?

In 2006, the cost of nursing home care in California averages $190 a day. Costs may be lower in rural areas and higher in suburban and urban areas. A short 30-day stay could cost $5,700 or more; a three-month stay, $17,100 or more; and, a year stay, about $69,350. Nearly 55 percent will stay at least one year. Twenty-one percent of the people who go into a nursing home will remain longer than five years.

That means more than half the people who go into a nursing home will spend between $69,350 and $346,750 or more. Consider this: care in your own home can be even more costly than care in a residential care or nursing facility, depending on how many hours of you have to pay for care.

The cost of care in the future will be much higher than it is today. California nursing home rates increased at an average rate of 5.4 percent per year over the past 20 years[2] . These costs are likely to continue to increase by at least 5 percent per year in the future. A 5 percent annual increase means a year of care that costs $69,350 today will cost twice that amount in 14 years, or $137,000 a year, and $300,000 a year 30 years from now!

## E. Who Pays For Long-Term Care?

**Medicare:** Medicare may pay for skilled care in a nursing home for a very short period--but no longer than 100 days--and only when the patient meets all the Medicare requirements for daily skilled care. For Medicare to pay for any days in a nursing facility, you will have had to spend at least three days in the hospital for the condition requiring admittance into the nursing facility. When Medicare pays for nursing facility care, it only pays the full costs for the first 20 days. For the next 80 days, your co-payment is $119 per day (based on the co-pay amount for Calendar Year 2006 that increases annually[3]), Medicare will pay the balance up to their maximum. Your Medicare supplement plan will pay this co-payment for you, but will not pay for additional days in the nursing facility beyond what Medicare will pay for. Most Medicare HMOs will cover nursing facility care or care at home for 100 days, if skilled care is required.

While people do get personal care services while receiving skilled care in a nursing facility, Medicare will not pay unless there is also a need for daily skilled services that only a nurse or therapist can provide. Medicare may pay for some personal care services at home but again, only if you also need skilled care on a daily basis that only a licensed person can provide. For more details, see the Medicare benefits book available from your Social Security office or by calling the Social Security Administration, toll-free at (800) 772-1213.

**Medi-Cal:** Medi-Cal (called Medicaid outside California) pays for necessary health care that is not covered by Medicare, but only if you meet federal and state poverty guidelines. In 2006, a single person over 65 would qualify for Medi-Cal if he/she had $2,000 or less in non-exempt assets. A spouse, living in the community, however, can keep up to $99,540 in non-exempt assets and $2,489 in monthly income, when his or her spouse is in a nursing home and applies for Medi-Cal. These guidelines and

[2] Issuers Bulletin 2006, California Partnership for Long-Term Care, based on data from the California Office of Statewide Health Planning and Development.

[3] www.medicare.gov, “Medicare Deductibles and Coinsurance Amounts for 2006”, 12/7/2005.

the amount of assets and income a person may keep can change annually. For more information, please access the following publication on the Internet at www.dhs.ca.gov/publications/forms/pdf/mc7inf.pdf.

Note: In general, the value of a person's house is not counted when applying for Medi-Cal. The state will recover the costs paid by Medi-Cal from a person's estate, which can include the house. Recovery will not occur while there is a surviving spouse or dependent child.

**Personal Resources:** Most people pay long-term care expenses from their own income and resources. When care is provided by family members and friends at home, other costs such as those for skilled care, equipment, transportation, and other costs not paid by Medicare are also paid from the patient's personal income or savings. People who use up their assets paying for long-term care are "spending down" and may become eligible for Medi-Cal as a result.

## Section Two: Partnership-Certified Long Term Care Insurance Policies

### A. What is the California Partnership for Long-Term Care?

The California Partnership for Long-Term Care (the Partnership), a program of the California Department of Health Services (DHS), is an innovative partnership between consumers, the State of California and five private insurance companies, plus the California Public Employees Retirement System (CalPERS). These insurers offer a long-term care policy that meet special requirements set by the DHS. Companies participating in the Partnership must have their Partnership policies approved by both the Department of Insurance and the DHS. The CalPERS policy is only approved by DHS.

Each Partnership-approved policy includes high quality insurance benefits to help pay for the care you may need and automatic inflation protection to ensure that the benefits keep pace with the rising cost of care. Partnership policies also include a unique state guaranteed asset protection feature that protects you against impoverishment due to the costs of long-term care, even if you use up all the benefits of your policy.

### B. What is long-term care insurance?

High quality long-term care insurance will pay the majority of the costs for a nursing facility or residential care facility. A high quality policy that includes coverage for care at home will provide a meaningful amount of money to help pay for a long-term care services to supplement the care provided by your friends or family.

### C. What types of policies are available under the Partnership?

Two types of Partnership-certified policies are available. Those that cover residential care facility and nursing facility only, and comprehensive policies that cover care in the home or in the community, in addition to a residential care facility or nursing facility. Home care only policies are not available under the Partnership.

• **Residential Care Facility (RCF) and Nursing Facility Only Policies:** These policies cover skilled, intermediate, or custodial care in a nursing home or similar facility. These policies also pay for board and care in a RCF.

• **Comprehensive Long Term Care Policies:** These policies pay for nursing facility care, board and care in a RCF, and home and community-based care. These policies must include at least the following benefits: a nursing facility benefit, a RCF benefit, home health care, adult day care, personal care (assistance with ADLs), homemaker services, hospice services and respite care. You can find definitions for each of these benefits in the glossary at the end of this brochure.

## D. What other special consumer protection provisions are included in Partnership-certified policies?

All Partnership-certified policies carry a special endorsement of the State of California and include important additional consumer protection features, including the following:

• Automatic built-in inflation protection - because long-term care costs will continue to rise, only policies with this feature will appropriately serve you in the future.
• Care coordination by a licensed health care professional independent of the insurance company to develop a Plan of Care based on individual needs and resources. The care coordinator can coordinate and monitor the quality of care if you wish.
• Minimum levels of benefits - to assure that your Partnership policy will pay a significant portion of your long-term care costs and minimize your out-of-pocket expenses at the time you need policy benefits.
• Monthly home and community-based care benefits that allow policyholders to obtain services that may exceed the amount available under fixed daily or weekly amounts.
• Special agent training requirements to ensure that Partnership policies are only marketed by licensed insurance professionals who have completed additional training required by the State of California.
• Waiver of premiums provision so you do not have to pay premiums when receiving benefits in a nursing or residential care facility.
• Maximums on the days that can be included in an elimination period, and prohibition against requiring you to meet more than one elimination period in a lifetime to maintain reasonable out-of-pocket expenses.
• Prior reviews of the policy's premiums to determine that they are reasonable and special rules that reduce the likelihood and/or amount of possible premium increase.
• Medi-Cal asset protection to safeguard assets equal to what your policy paid in benefits should you ever need to rely on Medi-Cal for continued long-term care.

## E. What is inflation protection and why is it such an important feature in a long-term care insurance policy?

All Partnership-certified policies automatically include an inflation protection benefit that increases the Daily Maximum Amount, all other benefit maximums, and the Maximum Lifetime Benefit by 5 percent every year. If you are under 70 years of age, the policy includes Inflation Protection that pays 5 percent compounded interest. With compounded interest, your previous year's Daily Maximum and Lifetime

Maximum Benefit will increase by 5 percent. Purchasers 70 years of age or older can choose a 5 percent simple inflation interest option instead of the yearly compounded interest option. If you choose an option that pays 5 percent simple interest, your original Daily Maximum and Lifetime Maximum Benefit will increase by the same amount each year.

Example: If you choose a $130 Daily Maximum with inflation protection of 5 percent simple interest, the Daily Maximum will be $195 after 10 years ($130 X 5% = $6.5 increase each year). If you choose Inflation Protection of 5 percent compounded interest, the Daily Maximum will be $211 after 10 years. Remember that it is likely that long-term care costs will double in about 14 years if inflation continues at the current rate.

Without inflation-protection, there is little, if any, chance that the policy you buy today will cover the inflated costs of long-term care 5, 10, or 15 years down the road. Even if future long-term care costs were to rise by only 5 percent a year, the cost of a nursing home stay would double every 14 years.

All Partnership policies include inflation protection to ensure that benefits keep pace with the rising costs of care. Here is an example of how this works:

> James and Robert are both 65-years-old and in good health. They both buy long-term care insurance policies on the same day in 2006. James buys a Partnership policy that, like every Partnership policy, includes inflation protection that increases benefits by 5 percent a year, compounded. Robert buys another long-term care policy without built-in inflation protection.
>
> Both of their policies have a total benefit limit of $138,700 ($190 daily benefit), which in 2006 is enough to pay for about two years of nursing home care. If they were to need long-term care within a few months, their policies would pay for $138,700 in long-term care, but it will be 20 years before James and Robert require long-term care.
>
> They will then be 85 and the cost for one year of long-term care is likely to have risen to $184,000; two years will cost $367,920! James' Partnership policy will now pay up to $368,000 in long-term care costs, because of its built-in 5 percent inflation protection feature.
>
> The policy that Robert bought without inflation protection will still only pay the original $138,700 in benefits. Robert's cost for his long-term care has risen to $368,000 and he will have to pay the difference - about $229,000 - out of his own assets and income.

## F. What is the advantage of the Partnership's care management provision and why is it so important?

The Partnership's care management/coordination requirement is designed to assist the policyholder in accessing the long-term care services needed to successfully remain in the most independent setting and with the least out-of-pocket expenses as possible. The Partnership requires that a Care Management Provider Agency, approved by the State Department of Health Services and independent from the insurer provide care coordination for Partnership policyholders.

Using a collaborative process, the care manager works with the policyholder, his or her family, and physician to complete a comprehensive assessment to determine the client's needs and resources and develop a detailed Plan of Care individualized to meet those needs.

- **Plan of Care:** In developing the Plan of Care, the care coordinator will consider the unique needs of the client and recommend alternatives for how those needs can best be met. It is likely that without the help of a care coordinator, a policyholder or family would have no idea of where to find someone to provide the necessary care. Partnership regulations require the care coordinator to consider how the policy benefits can help meet the policyholder's needs, and how the needs might also be met through other sources, perhaps through community services, or the client's health coverage, etc. This can help reduce the out-of-pocket expenses to the policyholder as well as help the policy benefits last as long as possible. This is especially important for a person who has a policy designed to pay benefits for only one or two years. Furthermore, since the Partnership requires the care coordinator to live in and be familiar with the community in which the policyholder resides, he or she will have a good understanding of where the quality providers are.

- **Care Implementation and Monitoring:** In addition to completing a comprehensive assessment and Plan of Care, the care coordinator can also contact the caregivers and arrange for them to be in the home to provide care at the required times, negotiate rates of payment, and monitor the quality of the services provided if desired by the policyholder.

## G. What are the minimum daily and lifetime benefits established by the Partnership and why are they so important?

**The Daily Maximum:** When you buy a policy you choose the amount you want the company to pay for each day of your care in a nursing facility. Most companies allow you to select as little as $50 daily or as much as $500 daily. When you need care, companies pay the daily benefit amount you selected or the actual cost, whichever is less. Some benefits may be paid as a percentage of another. For instance, a policy may pay $130 a day for care in a nursing home, a minimum of 70 percent of that amount for assisted living in a RCF, and a minimum of 50 percent for home care.

**Partnership Daily Nursing Facility Benefit:** Partnership policies cannot be sold with coverage that will pay less than 70 percent of the average daily private pay rate in a California nursing facility. Since the costs in California for a private nursing facility average $190 a day in 2006, coverage in a nursing facility for a Partnership policy can be no less than $130 a day (70 percent of $190, rounded to the nearest $10). In developing this minimum coverage amount, the Partnership assumed most people with middle incomes would likely be unable to afford to pay higher co-pay, which is the difference between what the policy will pay and the actual costs of care.

**Selecting the Daily Maximum:** Because you will be responsible for all expenses not paid by your insurance policy, you need to decide how much of the daily cost of care you can pay yourself. Estimate the daily cost in a nursing facility in your community and subtract the amount you can afford to pay for each day of your care. For instance if the cost of nursing facility care in your community is $190 a day and you can afford to pay a co-payment of $50 a day you will need the insurance company to pay $140 a day, or $4,200 each month.

**How Inflation Impacts Your Co-Payment Amount:** Remember that inflation is likely to result in nursing facility costs doubling every 14 years, assuming costs continue to rise by about 5 percent a year. Using the previous $140 daily benefit example, because of the inflation adjustment built into your policy, in 14 years your policy would pay $277 a day, and your co-payment would be $100 a day ($377 the actual cost of care - $277 what you policy would pay = $100 co-payment). If you are concerned you will not be able to pay this much out-of-pocket 14 or more years from now, you may wish to increase the policy's daily coverage in a nursing facility to a greater amount.

**Maximum Lifetime Benefit:** When you buy a long-term care policy you choose the maximum lifetime dollar amount for approximately the number of years you want the policy to pay benefits. The premiums you pay will be based in part on the number of years the policy will pay. While everyone would like to have lifetime coverage or unlimited benefits, not everyone can afford to do so. A policy that pays for a few years can provide valuable coverage, and will be all many people will need. Do not pass up long-term care insurance just because you cannot afford lifetime coverage.

**Selecting the Maximum Lifetime Benefit:** No one can predict how many days or years of long-term care a person will need, or the reason they will require care. Some people can afford lifetime coverage; others have so little money they would quickly qualify for Medi-Cal once they begin paying for long-term care. Choosing the right amount of benefit depends on the premium you can afford, and the assets you would otherwise have to spend.

**Partnership Requirements:** Partnership-certified policies cannot be purchased for less than an equivalent of the cost of one-year's stay in a nursing home. Since the premium for lifetime coverage is not affordable for many people, Partnership policies offer another method of selecting the Maximum Lifetime Benefit. - Choose the period that is roughly proportional to your current non-housing assets that you might otherwise have to use to pay for your care. (Remember that the value of your house is not counted when applying for Medi-Cal, but can be collected against if it is part of your estate). The following section will provide a better explanation of how the Partnership's unique Asset Protection benefit can impact your decision on your policy's Maximum Lifetime Benefit.

## H. How does Medi-Cal Asset Protection work?

Medi-Cal Asset Protection is available only in Partnership policies. This important feature guarantees that you may apply to Medi-Cal and be entitled to keep the assets Medi-Cal normally allows, plus assets equal to the amount your Partnership policy paid out in benefits for your care, should you use up your long-term care insurance benefits and still need long-term care. The State of California will also disregard these protected assets when it recovers from your estate the amount paid by Medi-Cal on your behalf.

To protect your earnings and savings, consider the tale of Evelyn and Janet:

> Both are healthy 65-year-old Californians who each have $138,700 of assets in the bank. Both own homes that are fully paid for and both have the same amount of money budgeted to spend for long-term care insurance. They both buy long-term care insurance policies with two years of benefits with inflation protection. Evelyn buys a Partnership policy while Janet buys a

Non-Partnership long-term care insurance policy with inflation protection. Twenty years later at 85, Evelyn and Janet both require long-term care and begin to draw their insurance benefits. During those 20 years, the price of long-term care services in a nursing home has increased to approximately $184,000 per year in California. Both women require care for several years. Their insurance benefits run out after two years. Each woman has received over $368,000 in benefits. Up to this point, their long-term care costs and benefits have been identical. With their insurance benefits exhausted, they both turn to Medi-Cal to help pay for the additional long-term care they need.

Because Evelyn's Partnership policy paid $368,000 toward her care, she is allowed to keep $368,000 in assets, plus the normal $2,000 Medi-Cal allowance when her Medi-Cal eligibility is determined. Sadly, Janet did not buy a Partnership policy. Medi-Cal required her to spend her assets down to $2,000 before they would begin to pay for her needs.

Both are required to spend their monthly income, less $35, to help pay for the cost of their care and both women are allowed to keep their homes. Both women continued to receive long-term care services for the remainder of their lives, during which time Medi-Cal paid out a total of $150,000 for each of them.

At the time of her death, Janet's savings remains at $2,000 and her home is valued at $200,000. To cover the cost of the care it paid for, Medi-Cal places a claim on Janet's home and the $2,000 savings. Evelyn's home is also valued at $200,000, and she has $100,000 in savings, all of which are protected, because she qualifies for $368,000 in asset protection from the benefits paid by her Partnership policy. Medi-Cal recovers nothing from Evelyn's estate, allowing Evelyn to leave her home and savings to her heirs.

Janet and Evelyn paid the same premiums (the asset protection benefit in Evelyn's policy was free). They received the same amount of long-term care. It just cost Janet more to get her care.

## I. Why does the Partnership require that policies calculate the home and community-based care benefits reimbursements on a monthly, rather than daily benefit?

What is the advantage of this to policyholders? In answering this question lets use an example where a policy was purchased that pays $130 a day for care in a nursing home, and 50 percent of that amount for home care. Many non-Partnership policies stipulate that the policyholder must either use the daily benefit ($65 a day using the above example) or be unable to access those dollars to pay for benefits for another day during that month. Other non-Partnership policies offer the home care benefit as a weekly benefit ($65 times 7 days a week = $455 a week). A weekly benefit is a great improvement over having the benefit capped on a daily basis, but again doesn't allow the policyholder to carry over any of the benefit money not used during one week to pay for additional care that may be required other days during the month.

All California Partnership policies provide policyholders with a monthly "bucket of money" to allow the greatest flexibility to receive home care benefits. This is how it works: if you do not need to use your home care benefit on a particular day (for example, a Saturday or Sunday when a spouse or other informal caregiver is home and can provide the care, these benefits remain available to pay

for care other days during the month, when no help is available or when more help is needed. This helps reduce the out-of-pocket expenses. Here is an example of how this works:

Sam and Andrew each have long-term care policies with a $65 a day home care benefit. The only difference between their policies is that Andrew's policy is a Partnership-certified policy with the monthly "bucket of money" feature, while Sam bought an ordinary long-term care policy with a fixed daily benefit.

Both Sam and Andrew are attended by their respective children and grandchildren, Thursday through Sunday. On Monday, Tuesday and Wednesday, Sam and Andrew need to pay a caregiver for 10 hours of care a day at a cost of $8.50 per hour (total cost per month equals $1,020). A visiting nurse visits each of them to check their medications and record their vital signs (cost $100) on Tuesdays (additional cost of $400 per month).

Sam's daily benefit caps out at $65 a day. Every Monday, Tuesday and Wednesday he must pay the caregiver $20 a day out of his own pocket ($85 total daily cost minus $65 benefit). In addition he must pay the visiting nurse $100, which is above the daily benefit amount. Considering that there are four weeks per month, Sam's out of pocket expense is $640 per month. Andrew, on the other hand, has $1,950 a month ($65 a day times 30 days in the month) to pay for these services. This means that on those days Andrew does not need to spend any money, that day's benefit is saved for use later in the month. With Sam's daily benefit, the unused benefit is not available to augment days when more than $65 of services is needed.

At the end of the 30-day month, both men will have received exactly the same services, but Andrew will have paid nothing out of his pocket and Sam will have paid $640.

## J. What is an Elimination Period, and what consumer protections are included in Partnership-certified policies?

**Elimination Periods:** The Elimination Period (sometimes called a "Waiting Period" or "Deductible Period") is the period of time you must wait after you qualify for care, and are eligible to receive benefits before the company will begin paying for your care. You choose the length of the Elimination Period when you buy the policy. The most common options are 0 days, 30 days, 60 days, 90 days or 100 days. Some policies only make you meet the Elimination Period once during the life of the policy; others apply it again after you have gone for a certain period of time without needing care. In most situations, the elimination period will be satisfied adding up the days you have to pay for either in-home care or institutional care.

The elimination or deductible period is the length of time that the insurer pays no benefits. If you select a 0-day Elimination Period, the policy will begin paying on the first day you qualify for care. If you choose one of the other periods, you will be responsible for paying the full cost of your care for these days.

Example: If you choose an Elimination Period of 60 days, you will be responsible for the cost of the first 60 days of your care. If you are in a nursing home that charges you $190 per day, you will pay approximately $11,400 ($190 per day X 60 days), before the policy starts paying. If you leave the nursing home before the 60 days expires and the policy only pays for institutional care, it would pay nothing for that period of care.

If you qualify for benefits in a home care setting most long-term care insurance policies apply a day towards your Elimination Period for any day you actually receive formal (paid for) care. Therefore, if your plan of care only calls for three visits per week you will only satisfy three days towards your Elimination Period. Some companies offer a more liberal interpretation of this definition. For example, the policy might say that if you have one home care visit per calendar week that you have satisfied seven days towards your Elimination Period. In this example, you would satisfy your Elimination Period more quickly.

The premium cost is usually higher if you choose the shorter Elimination Periods and is lower if you choose a longer period. In addition, a premium might be higher when the company uses a more liberal "counting" of home care Elimination Period days.

**Partnership Requirements for Elimination Periods:** The Partnership will not allow the Elimination Period to be longer than 30 days for a policy that will pay less than the equivalent of two years in a nursing facility. **Similarly, the Partnership will not allow more than a 90-day elimination period for policies that will pay more than the equivalent of two years in a nursing facility. Other elimination periods can be offered in addition to the 90-day option, but not more than 90 days.** You can always choose a shorter Elimination Period. In developing these minimums, the Partnership assumed that a person, who chose a policy that would pay benefits for a period less than the equivalent of two years in a nursing facility, might not easily be able to afford the out- of-pocket expenses associated with longer Elimination Periods. In addition, Partnership-certified policies require the insurance company to also count days Medicare pays for long term care to count toward meeting the Elimination Period.

Finally, the Partnership requires that the Elimination Period be met only once in a lifetime. For example, should you meet your Elimination Period and begin receiving policy benefits in your home, you cannot be required to meet the Elimination Period again to use your policy benefits at a later time to pay for care in a nursing facility.

**Selecting the Elimination Period:** Multiply the current cost of one day of care by the number of elimination days you plan to use. (Example: $190 x 30 days = $5,700). Then estimate the number of days you could afford to pay for your own care without liquidating any assets. That is the maximum number of days you should select as an Elimination Period. Although choosing a short Elimination Period increases your premium, the amount you will pay for your own care during an Elimination Period is likely to be much more expensive. Another factor to take into account is that the daily cost of care doubles about every 14 years. Your out-of-pocket cost for the Elimination Period you choose will increase as well.

## K. What are the Partnership's requirements regarding Waiver of the Policy Premiums?

Many policies allow you to stop paying premiums while the policy is paying benefits (usually after a waiting period). Partnership policies must waive the requirement to pay premiums once you are receiving the policies benefits either in an RCF or in a nursing facility. Some Partnership policies also waive premiums while you are using the home care benefits. Be sure to ask your agent to explain how the premium waiver works in any policy you are considering.

## L. When will the Partnership-certified long-term care insurance begin paying benefits?

All long-term care policies require that your physical or mental conditions meet certain standards before benefits will be paid. These standards are often called Benefit Triggers. The two Benefit Triggers allowed in Partnership-certified long-term care insurance policies in California are:

### 1. Impairment in Activities of Daily Living (ADLs)

"Activities of Daily Living" (ADLs) are used to measure your physical abilities to determine if you qualify for benefits. The law requires tax-qualified policies to pay benefits if you are impaired in two out of the following six ADLs: bathing, dressing, transferring, eating, toileting and continence. Only two ADLs can be required before benefits will be paid for nursing home care, RCFE care, or home care. "Impairment" means that you need human assistance or continual supervision to perform an Activity of Daily Living.

### 2. Impairment in Cognitive Ability (or Cognitive Impairment)

"Impairment in Cognitive Ability" means that you need supervision or assistance to protect yourself or others because of mental deterioration caused by a mental disease such as Alzheimer's disease or a mental illness. A diagnosis of cognitive impairment is based on clinical evidence and by the use of standardized tests.

## M. What does a Partnership long-term care insurance policy cost?

The costs of policies vary by the amount of coverage you choose after qualifying for benefits, the length of coverage (from one year to lifetime) and your age when you purchase. Policies can be customized to fit the needs and pocketbooks of Californians of all income levels. In general, Partnership policies cost the same or slightly less than other policies that offer similar coverage. Only Partnership policies, however, include Medi-Cal asset protection - a significant benefit at no additional cost.

Each insurance company approved to offer Partnership policies has its own premium rates. However, the younger you are when you purchase coverage, the less expensive your annual premium will be.

## N. Why should I buy a Partnership policy if I will be residing outside of California?

A person must be a California resident to buy a Partnership-certified long-term care policy. A person with a Partnership policy can access the policy benefits anywhere in the United States, and even abroad with some companies. Moreover, with a Partnership policy, you can rest knowing you are receiving benefits with top quality consumer protection features.

The only feature of the policy that is not recognized outside of California is the unique Medi-Cal asset protection. The California Medi-Cal program only recognizes asset protection. You would have to return to California to apply for Medi-Cal once policy benefits are used up in order to take advantage of the Partnership asset protection and avoid Medi-Cal spend down.

Today, many families are geographically scattered throughout the country. Some people will return to California to be near their family when long-term care is needed to ensure they have the support to help provide, manage or monitor their care. Having a Partnership-approved long-term care insurance policy can ensure that you have a quality policy where ever you may go, and Medi-Cal asset protection should you return to California.

## O. Why should I buy a Partnership policy if I can afford lifetime coverage?

With a lifetime benefit policy the unique asset protection feature may not end up being of any value to you. It costs you nothing, however, to have the asset protection included in the policy. It is true that a non-Partnership policy may meet your needs just as well. On the other hand, none of us can see into the future. What would happen if you could no longer afford the premiums associated with a lifetime policy and need to reduce coverage to a policy that would pay the equivalent of one to three years in a nursing facility? If you found that necessary, under a Partnership policy you would have the advantage of the asset protection feature should you use up your policy benefits and need Medi-Cal to pay your nursing facility costs.

## P. Who endorses the California Partnership for Long-Term Care?

Many influential California organizations and associations endorse the Partnership program and policies. They include:

California Medical Association (CMA)
California Commission on Aging
California Retired Public Employees Association
California State Employees Association
California Association for Adult Day Services
California Association for Health Services at Home
California Association of Health Facilities
California Association of Homes and Services for the Aging
California Association of Residential Care Homes
California Pharmacists Association's Long-Term Care Management Council
Community Residential Care Association of California
Mt. Zion Institute on Aging
Senior Care Network/Huntington Memorial Hospital

### Q. How can I get more information on long-term care or the California Partnership for Long-Term Care?

For more information, contact the California Partnership for Long-Term Care at **1-800-CARE-445** or visit the Partnership Web site at **www.dhs.ca.gov/cpltc.**

The following is a list of private participating insurance companies and CalPERS that provide Partnership-certified long-term care policies.

**Bankers Life and Casualty**
(888) 2828-BLC

**CalPERS Long-Term Care Program***
(800) 205-2020

**Genworth (formerly, GE Financial Assurance)**
(800) 354-6896

**John Hancock Life Insurance Company**
(800) 377-7311

**MetLife**
(888) 4CA-PLAN

**New York Life Insurance**
(800) 224-4582

*All California public employees, retirees and their spouses, siblings (age 18 and older), parents and parents-in-law are eligible to apply. Call CalPERS for application period dates.

## Section Three: Consumer Protections Required in All Long-Term Care Insurance and Other Considerations When Purchasing a Policy.

## A. What consumer protections apply to long-term care insurance sold in California?

California has a long list of consumer protections, some of which are listed here.

**Guaranteed Renewable:** This means that the insurer may not cancel coverage unless premiums are not paid on time. Coverage may not be cancelled because of age or health, but the company retains the right to increase premiums if the Department of Insurance approves the increase.

**Duty of Honesty, Good Faith, and Fair Dealing:** Every long-term care insurer and insurance agent owes every applicant and policyholder a duty of honesty, good faith, and fair dealing. Among other things, this duty means that advertisements and other marketing materials may not be misleading. Applicants must be given fair and accurate comparisons of policies. No excessive insurance or inappropriate replacement policies may be sold. High-pressure sales tactics are expressly forbidden, and insurance agents must receive special training in order to sell long-term care insurance.

**30-Day Free Look:** Purchasers of individual long-term care insurance (except purchasers through employer groups or trade associations) have the right to review the policy or certificate for 30 days after they receive it. If the purchaser decides not to buy the insurance, for any reason, it can be returned to the insurer or the agent without explanation with a full refund. (Note: Always keep a record of the date the policy was received and the date it was returned, or return it by certified mail.)

**Outline of Coverage:** An outline of coverage is a summary of the terms of a policy or certificate that can be used to compare different policies. An Outline of Coverage must be delivered at the time of an insurance agent's first presentation. When purchasing insurance through the mail, the Outline of Coverage must be delivered at the time the application or enrollment form is received. It is not necessary to fill out an application in order to get the Outline of Coverage. An agent or insurance company should be readily willing to provide an Outline of Coverage.

**Changing Your Benefits:** If you find that you cannot afford to continue paying the same amount of premiums for the coverage you bought, you have the right to reduce your benefits in return for a lower premium. Companies must, at a minimum, let you reduce the daily benefit or change the number of years the company will pay to reduce the premium to an amount that is more affordable.

**Shoppers Guide:** Companies and agents are required to provide a copy of the long-term care insurance shoppers guide developed by the California Department of Aging to each person who applies for a long-term care insurance policy. This guide is entitled "Taking Care of Tomorrow" and covers many issues related to long-term care, as well as long-term care insurance.

**Checklist and Counseling Information:** Agents are required to leave a number of documents with the purchaser of a long-term care insurance policy. Among the documents you should get is a copy of a "Personal Worksheet" that helps you understand some of the issues related to purchasing long-term care insurance, and the name, address, and local phone number of the Health Insurance Counseling and Advocacy Program (HICAP) office nearest you where you can receive, free of charge, information and counseling about long-term care insurance.

## B. Can I afford long-term care insurance?

Most people should not spend more than 7 percent of their total annual income on annual premiums for a long-term care insurance policy. Estimate your discretionary income by subtracting your fixed expenses from your annual income. Then decide how much of that discretionary income you want to spend on long-term care insurance premiums. Remember that after retirement, income often does not keep pace with

inflation. As you age, you are more likely to have unexpected medical expenses, such as prescription drugs or other medical costs that may not be covered by your medical insurance. The loss of a spouse can also result in reduced income. Select a premium you can comfortably afford. Take into consideration that your premium may increase during the years you own the policy. When talking to an agent about long-term care insurance it is important for you and your agent to understand your financial circumstances so that he/she can tailor a plan best suited to your needs.

## C. Should I replace my existing policy with a newer one?

The advantage of replacing an older policy is that newer policies may offer benefits that are more desirable and features and fewer restrictions. Assisted living in an residential care facility, home care benefits, inflation protection, and no requirements for a prior hospital stay are some of the benefits and features being offered in current long-term care products. However, just because a policy is newer does not necessarily mean it is better than the one you have.

One disadvantage to replacement is that the insurance company will charge higher premiums because you are older than you were when you bought your original policy. In addition, if you have any pre-existing conditions or are 80 years old or more companies may refuse to issue new coverage. If you are still insurable, you might consider adding new coverage to the benefits you already have, or buying an additional policy to supplement your existing benefits. Even very old policies still provide a benefit, and the premiums are often much less expensive than a premium for a brand new policy at an older age. Before you add benefits to an existing older policy you should check with your agent, company, or tax advisor to see if you will lose the grandfathered tax status granted policies purchased before January 1, 1997.

If you are considering replacing an older policy, first ask your current agent or insurer if you can update your coverage. If you replace your policy with the same company, you are likely to get a credit for some percentage of the premiums you have already paid against the new premium. Another possibility is to keep the older policy and add a newer one to supplement the daily benefit in the old policy, or add some of the newer benefits not in the older policy. Adding another policy will not cause the loss of any tax advantages you have for the older policy. Whenever you are considering replacing a policy, consulting a HICAP counselor is recommended.

## D. How do I choose a qualified long-term care insurance agent?

Here are some important things to determine about your prospective agent.

Make sure the agent is certified to sell long-term care insurance. This means that he/she has taken two 8-hour certification courses within the last 24 months. If the agent has been licensed for less than five years, he or she will have taken an 8-hour certification course every 12 months. **Agents selling the California Partnership policies will have taken an additional 8 hours of training that allows them to understand the unique provisions of a Partnership-certified policy.**

A qualified long-term care insurance agent should be able to help you sort through the clutter of company and benefit choices. Much of the decision making process revolves around your age, health conditions and financial resources. To assist the agent in finding the best long-term care insurance policy for your needs, you need to find an agent you can trust and have a candid conversation with him/her regarding all of these

matters. It is also helpful to have your family present when talking to the agent so they can also ask questions important to them.

Notice if the agent asks the right questions. Without knowing your financial circumstances and health status the agent cannot possibly provide you with the best choices. A competent agent should be able to show you what the premium would be from several companies for benefits that fit your needs and that you can afford.

A good agent will not just sell you a policy but will be there to help you when you have questions, need to make change, or have a claim. Make sure that the agent you select has a good history and track record in providing on-going services to his/her clients. Do not be shy about asking for references. You can also check out an agent by going to the Department of Insurance Website at http://www.insurance.ca.gov/.

The agent should provide you with:

1. Outline of coverage
2. Personal Worksheet
3. The Buyer's Guide "Taking Care of Tomorrow"
4. The name, address and phone number of your local HICAP office
5. What Happens When Long Term Care Costs Rise? A Comparison of Care Costs and Benefit Amounts

If the agent is discussing a Partnership-certified policy with you, you should also be provided with a copy of "Before You Buy". This document explains the Partnership's unique asset protection provision discussed earlier in this brochure. You should get these documents even if you do not agree to buy a policy that day.

## E. How do I choose an insurance company?

Verify the insurance company's financial standing and track record. This is very important before choosing a long-term care insurance policy. Consumers should also consider the how often the company has increased rates in the past. This rate increase data is available by contacting the California Department of Insurance at 800-927-HELP or by going to the Department of Insurance Website at www.insurance.ca.gov. Ask for the "Long-Term Care Insurance Company Rate and History Guide.

Financial Standing: A company's size and ratings are important factors to take into consideration when making your long-term care insurance choice. While an A+ rating is no guarantee the company will remain in business or not increase their premiums, companies with superior ratings are more likely to have the ability to pay future claims. The rating services you should look to include:

A.M. Best (908) 439-2200 (www.ambest.com)
Standard & Poors (212) 438-7280 (www.standardandpoors.com)
Moody's (212) 553-0377 (www.moodys.com)
Fitch Financial (800) 893-4824 (www.fitchratings.com)
Weiss Rating, Inc (800) 289-9222 (www.weissrating.com)

A.M. Best rates all long-term care insurance companies. Most carriers have ratings from one or more of the other services listed. Ask your agent to provide you with the most recent rating statistics.

**Underwriting standards:** Do not be discouraged by a company that carefully evaluates your health. Long-term care insurance companies that use firm and consistent underwriting standards should, over the long run, have more stable premiums. This is because they are careful about the risks they accept and likely to have more predictable claims results.

Do not be misled by the names attached to a company's underwriting classes (such as preferred, standard, substandard). You will not always qualify for a company's "preferred" rate class. What is important is that the company carefully reviews your health history, the results of your telephone interview and/or a face-to-face assessment and then makes an offer of insurance based on those results. "Easy-issue" offers mean that a company may be issuing insurance to people who already have serious health conditions and will definitely need long-term care. Such a practice can in turn lead to higher premiums for everyone who bought insurance from that company.

**Group or Self-Insured Plans:** Long-term care insurance offered on a group basis that is self-insured does not necessarily have the same strict consumer protection provisions that apply to individual long-term care insurance. Work with a qualified long-term care insurance agent to determine your priorities so that you can make the best choice for your long-term care insurance needs.

**Premium costs:** You get what you pay for. If a policy looks too "cheap" it probably is. Long-term care insurance has many optional benefits and nuances. Work with an agent who asks good questions and works with your personal situation to design a benefit package that suits your needs.

**Experience in Long-Term Care Insurance:** Long-term care insurance is a relatively new product. While a handful of companies have offered long-term care insurance for a decade or more, there are many fine product offerings from high quality companies that have recently entered the marketplace. Some companies have long experience with this type of insurance, while others have less. Experience is just one more element to evaluate when purchasing this type of insurance.

## Section Four: Glossary of Terms and Other Sources of Information

## GLOSSARY OF TERMS

**Activities of Daily Living (ADL)** - Everyday functions and activities individuals usually do without help. ADL functions include bathing, continence, dressing, eating, toileting, transferring, and for non-tax qualified policies, ambulating. Many policies use the inability to perform a certain number of ADLs (such as 2 of 6) to decide when to pay benefits.

**Adult Day Care** - Care during the day for adults, usually at a senior or community center.

**Alzheimer's Disease** - A progressive, degenerative form of dementia that causes severe intellectual deterioration.

**Assisted Living Facility** – In California, a licensed residential care facility or residential care facility for the elderly.

**Benefit Triggers** - Term used by insurance companies to describe when to pay benefits.

**Care Management or Care Coordination Services** - A service in which a professional, typically a nurse or social worker, may arrange, monitor, or coordinate long-term care services.

**Cognitive Impairment** -A deficiency in a person's short-or long-term memory; orientation as to person, place and time; deductive or abstract reasoning or judgment as it relates to safety awareness.

**Community-Based Services** - Services designed to help older people stay independent and in their own homes.

**Custodial Care (Personal Care)** - Care to help individuals meet personal needs such as bathing, dressing, and eating. This is also known as unskilled care that may be provided by someone without professional training.

**Daily Benefit** - The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

**Dementia** - Deterioration of intellectual faculties due to a disorder of the brain.

**Elimination Period** - A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments. The longer the elimination period in a policy, the lower the premium.

**Guaranteed Renewable** - When a policy cannot be cancelled and must be renewed when it expires unless benefits have been exhausted. The company cannot change the coverage or refuse to renew the coverage for other than non-payment of premiums.

**Health Insurance Portability and Accountability Act (HIPAA)** - Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.

**Home Care** - Includes the following: home health care, adult day care, personal care, homemaker services, hospice services and respite care.

**Homemaker Services** - Household services done by someone other than yourself because you are unable to do them.

**Inflation Protection** - A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services.

**Lapse** - Termination of a policy when a renewal premium is not paid.

**Medicaid (Medi-Cal in California)** - A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

**Medicare** - The federal program providing hospital and medical insurance to people aged 65 or older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited.

**Medicare Supplement Insurance** -A private insurance policy that covers many of the gaps in Medicare coverage.

**National Association of Insurance Commissioners (NAIC)** - Membership organization of insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.

**Non-Cancelable Policies** - Insurance contract that cannot be cancelled, nor can the rates be changed by the insurance company.

**Pre-existing Condition** - Illnesses or disability for which you were treated or advised within a time period before applying for a life, health or long-term care insurance policy. Policies with limits on covering pre-existing conditions restrict benefits related to those conditions for a specified period, usually six months from the date coverage starts

**Premium** – A specified sum of money payable to an insurance company for an insurance policy that guarantees the payment of specified benefits. This payment may be a single sum or periodic payments.

**RCFE** – Residential Care Facilities for the Elderly.

**Rescind** - When the insurance company voids a policy back to the inception date.

**Respite Care** - Offers a few hours to several days of help to relieve family caregivers.

**Spend Down** – A process of spending excess assets to meet Medicaid eligibility requirements.

**Substantial Assistance** – A term meaning “hands-on” or “stand-by” help required to perform an ADL.

**Substantial Supervision** - A term that means the presence of a person directing and watching over another who has a cognitive impairment.

**Tax-Qualified Long-term care Insurance Policy** - A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

**Underwrite** – A method insurers use to evaluate an individual’s personal health and potential claim risk in determining whether to issue a policy and sometimes how much to charge as a premium.

**Waiver of Premium** - A provision in an insurance policy that lets you stop paying premiums once benefits have begun. The point at which the waiver begins and ends differs from policy and policy.

| If you Have Questions | Contacts |
|---|---|
| Specific insurance companies or agents | California Department of Insurance<br>300 South Spring Street, South Tower<br>Los Angeles, CA 90013<br>(213) 897-8921<br>(800) 927-HELP (4357)<br>***Email: E-Mail Department of Insurance***<br>**Department of Insurance Website** |
| Purchasing long-term care insurance in California | California Department of Insurance<br>(For a Consumer Guide to Long-Term Care Insurance)<br>(800) 927-HELP<br>(800) 927-4357<br>**Department of Insurance Website** |
| Issues pertasining to seniors<br>(housing, transportation, other) | California Department of Aging<br>Health Insurance, Counseling and Advocacy Branch<br>1600 K StreetSacramento, CA 95814<br>(916) 322-3887<br>(800) 510-2020<br>**Department of Aging Website** |
| Understanding and using a policy | Health Insurance Counseling and AdvocacyProgram (HICAP)<br>(800) 434-0222 |
| A health care provider's licensing and certification | California Licensing and Certification<br>Department of Health Services<br>1800 Third Street, Suite 200<br>Sacramento, CA 95814<br>(916) 445-2070<br>**Licensing and Certification Website** |
| General guidelines on long-term care policies | National Association of Insurance Commissioners<br>2301 McGee, Suite 800<br>Kansas City, MO 64108-2604<br>(816) 842-3600<br>**National Association of Insurance Commissioners Website** |

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|---|---|
| Long-term care resources and other Senior health issues | Family Caregiver Alliance<br>690 Market Street, Suite 600<br>San Francisco, CA 94104<br>(415) 434-3388<br>Email: ***Family Caregiver Alliance E-Mail***<br>***Family* Caregiver Alliance Website** |
| Free health insurance counseling and information | ElderCare Locator<br>(800) 677-1116<br>**ElderCare Locator Website** |
| Medical Directives | Health Advocacy Services<br>American Association of Retired Persons<br>Programs Division<br>Stock #EE0976<br>601 E Street NW<br>Washington, DC 20049<br>**AARP Website** |

**For more information, visit the Partnership website at www.dhs.ca.gov/cpltc**